U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 20Sep2002

IN THE MATTER OF:

DONALD B. CHURCH
Claimant,

v. Case No.: 1999-BLA-00972

VIRGINIA POCAHONTAS CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES: Joseph E. Wolfe, Esq.
For the Claimant

Douglas Smoot, Esq.
For the Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER DENYING LIVING MINER'S BENEFITS

This case arises from a claim for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718[1] and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

This claim was referred for a formal hearing to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs ("Director" or "OWCP") in accordance

[1] Citation to the regulations at 20 C.F.R. Part 718 shall constitute reference to the amended regulations unless otherwise noted.

with the provisions of the Act and the regulations issued thereunder. After due notice a hearing was held in Abingdon, Virginia, on April 4, 2001. Claimant and Virginia Pocahontas Company ("employer") were represented by counsel.

Based on the entire record, the following is entered.

Findings of Fact

1. Claimant is Donald Church, an individual whose address of residence is P.O. Box 281, Clinchco, Virginia 24226.

2. Employer is Virginia Pocahontas Company, a business entity whose address is 2355 Harrodsburg Road, Lexington, Kentucky 40504.

3. Claimant worked as a coal miner as that term is defined by Section 402 (d) of the Act and 20 C.F.R. §725.202 for 15 years.

4. Claimant was employed for several underground coal mine employers between 1954 and 1975. Virginia Pocahontas Company was the last coal mine employer for whom the claimant was employed for a cumulative period of one year. Claimant was employed for this company between 1970 and November of 1975.

5. Claimant testified that his last coal mine employment with Virginia Pocahontas involved shooting rock with dynamite and drilling with a jack hammer.

6. All of Claimant's coal mine employment was underground. He testified that he generally worked at the face and the various jobs he performed included drilling and shooting, loading coal, operating a buggy, and stoker.

7. Claimant testified that he smoked cigarettes on and off beginning in 1956 at age 19 and quitting completely in 1986. He estimates that he smoked approximately 21 years during this period because he would quit for several years at a time and he chewed tobacco for 4 to 5 years.

8. Claimant also testified that he quit work in 1975 because of his breathing problems which have become progressively worse.

9. Claimant testified that his treating physician is Dr. Robinette and that he has been on oxygen therapy for two years. He also indicated that his activity has become more limited since 1984 and that he has difficulty even walking.

10. Claimant has one dependent for purposes of augmentation of benefits, his wife, Leona.

11. The following are readings of chest x-rays taken of the claimant:

Physician	X-ray Date	Reading Date	Quality	Qualifi-cations	Impression
Morgan	4/24/74	3/14/84	1	B	Negative
Lapp	4/24/74	3/14/84	1	B	Negative
Renn	4/24/74	3/19/84	2	B	Negative
Scott	8/5/74	8/5/74	2	N/I	1/0, p, 2 zones
Pitman	8/5/74	5/1/75	N/I	N/I	0/0
Cunningham	11/7/74	3/17/84	fair-good	B	0/1 p,s 2 zones
Cunningham	5/25/80	4/2/84	good	B	0/1, p,p 2 zones
Cunningham	5/27/80	4/2/84	good	B	0/1, p,p 2 zones
Francke	10/7/80	5/27/83	3	B,BCR	0/0
Zaldivar	10/7/80	6/13/83	1	B	Negative for pneumoconiosis
Eryilmaz	10/10/80	10/11/80	–	N/I	0/1, p
Caday	10/10/80	4/10/81	–	N/I	0/1, p
Franke	10/10/80	6/22/83	1	B,BCR	Negative
Zaldivaar	10/10/80	9/15/83	3	B	Negative
Cunningham	10/10/80	4/2/84	poor	B	0/1 p,p 2 zones
Gale	5/10/82	8/16/82	–	N/I	1/0 p,q
Fisher	5/10/82	2/13/83	1	B,BCR	1/0 p,t 4 zones
Penman	5/10/82	5/9/83	good	N/I	1/1 p 4 zones
Ramakrishnan	5/10/82	8/26/83	1	N/I	1/0 q 4 zones
Bassali	5/10/82	3/29/84	1	B	1/1 p,s 6 zones

Cunningham	8/31/83	4/2/84	fair	B	0/1 p,p 2 zones
Paranthaman	8/26/98	8/26/98	1	B	0/1 s,t 2 zones
Navani	8/26/98	8/30/98	3	B,BCR	0/1 s,p 4 zones
Gaziano	8/26/98	9/18/98	1	B	1/2 t,t 4 zones
Wiot	8/26/98	1/22/99	2	B,BCR	Negative for pneumoconiosis
Spitz	8/26/98	2/5/99	2	B,BCR	Negative
Meyer	8/26/98	8/18/99	1	B,BCR	Negative for pneumoconiosis
Wheeler	8/26/98	3/2/00	3	B,BCR	Negative for pneumoconiosis
Scott	8/26/98	3/2/00	3	B,BCR	Negative
DePonte	1/19/99	1/20/99	1	B,BCR	1/0 s,s 4 zones
Wiot	1/19/99	2/26/99	1	B,BCR	Negaive
Spitz	1/19/99	3/5/99	1	B,BCR	Negative for pneumoconiosis
Meyer	1/19/99	5/19/99	1	B,BCR	Negative for pneumoconiosis
Scott	1/19/99	8/24/99	2	B,BCE	Negative for pneumoconiosis
Wheeler	1/19/99	8/26/99	1	B,BCR	Negative for pneumoconiosis
Kim	1/19/99	9/8/99	2	B,BCR	Negative for pneumoconiosis
Abramowitz	1/19/99	7/10/00	2	B,BCR	0/1 s,t 4 zones
Binns	1/19/99	7/19/00	3	B,BCR	0/1 s,t 4 zones
Gogineni	1/19/99	7/20/00	2	B,BCR	0/1 s,t 4 zones
Castle	2/9/99	2/22/99	2	B	0/1 s,t 2 zones
Wiot	2/9/99	3/8/99	1	B,BCR	Negative
Spitz	2/9/99	3/18/99	1	B,BCR	Negative

Meyer	2/9/99	5/19/99	2	B,BCR	Negative for pneumoconiosis
Scott	2/9/99	8/24/99	2	B,BCR	Negative for pneumoconiosis
Wheeler	2/9/99	8/26/99	2	B,BCR	Negative for pneumoconiosis
Kim	2/9/99	9/8/99	2	B,BCR	Negative for pneumoconiosis
Abramowitz	2/9/99	7/20/00	1	B,BCR	0/1 s,t 4 zones
Gogineni	2/9/99	7/20/00	1	B,BCR	Negative for pneumoconiosis
Robinette	8/16/99	8/16/99	1	B	1/1 q,t 4 zones
Wheeler	8/16/99	9/25/99	1	B,BCR	Negative for pneumoconiosis
Scott	8/16/99	9/24/99	1	B,BCR	Negative for pneumoconiosis
Abramowitz	8/16/99	7/20/00	1	B,BCR	0/1 s,t 4 zones
Gogineni	8/16/99	7/20/00	1	B,BCR	Negative for pneumoconiosis
McSharry	9/2/99	9/3/99	–	N/I	Negative for pneumoconiosis
Scott	9/2/99	9/9/99	1	B,BCR	Negative for pneumoconiosis
Wheeler	9/2/99	9/15/99	2	B,BCR	Negative for pneumoconiosis
Kim	9/2/99	9/22/99	2	B,BCR	Negative for pneumoconiosis
Abramowitz	9/2/99	7/20/00	1	B,BCR	Negative for pneumoconiosis
Gogineni	9/2/99	7/20/00	2	B,BCR	Negative for pneumoconiosis
Binns	9/2/99	7/19/00	2	B,BCR	0/1 s,t 4 zones
Robinette	3/27/00	3/27/00	1	B	1/1 q,r 4 zones
Patel	1/3/01	1/3/01	2	B,BCR	1/0 s,s 4 zones
Wheeler	1/3/01	2/7/01	1	B,BCR	Negative for pneumoconiosis
Scott	1/3/01	2/7/01	1	B,BCR	Negative for pneumoconiosis

Kim	1/3/01	2/19/01	1	B,BCR	Negative for pneumoconiosis
Gogineni	1/3/01	3/2/01	1	B,BCR	Negative for pneumoconiosis
Binns	1/3/01	3/5/01	1	B,BCR	0/1 s,t 4 zones
Abramowitz	1/3/01	3/5/01	1	B,BCR	0/1 s,t 4 zones

* B - B-reader
BCR - Board-certified Radiologist

12. The following are results of pulmonary function tests administered to claimant:

Physician/ Date	**FEV1**	**MVV**	**FVC**	**Age/ Hgt**	**Co-op Comp**	**Trac-ings**
Hatfield 8/2/74	1.89	–	2.75	37 74"	No effort	Yes
Buddington 4/8/77	1.88	71	3.8	40 72"	Good	Yes
Buchanan General 6/9/80	1.94 2.44*	52 80*	4.01 4.4*	43 72"	Good	Yes
Kress 10/7/80	2.1	49	4.4	43 71"		Yes
Paranthaman 8/26/98	.51 .81*	21 33*	1.91 3.05*	61 72.5"	Good	Yes
Castle[2]	.79	26	2.93	62	Good	Yes

[2]Concerns regarding the medical technician, Rod Pritchard, who performed the pulmonary function and blood gas tests for Dr. Castle's examination on February 9, 1999 were raised at a hearing in this case which was held on October 19, 1999. Claimant alleged that Pritchard was not properly licensed by the State of Virginia to conduct medical tests and had subpoenaed Pritchard to testify at this hearing. Pritchard's attorney, Scott Mullins, appeared on his behalf and moved to quash the subpoena on the basis of Pritchard's 5th Amendment privilege against self incrimination since the matter of whether Pritchard needed a license to conduct medical tests was still pending before the Virginia Department of Health Professionals. For this reason, and others, that hearing was continued. It appears from other letters and communications that a final determination on this matter is still pending. Thus, Pritchard's attorney has continued to advise him to assert his 5th Amendment right and to not testify in regard to the tests he conducted in this case as well as

2/9/99	1.01*	38*	4.23*	70"		
McSharry	.84	28	3.40	62	Good	Yes
9/2/99	1.28*	–	4.92*	72"		
Rasmussen	.78	22	2.79	63	N/I	Yes
1/3/01	.96*	33*	3.73*	71"		

* Results post-bronchodilator

13. The following are results of blood gas studies administered to claimant:

Date	**Doctor**	**PCO2**	**PO2**
7/7/76	Buddington	35	60
6/9/80	Buchanan General	38	64
6/12/80	Buddington	35	62.3
10/7/80	Kress	43 43*	83 88*
8/26/98	Paranthaman	48	74
2/9/99	Castle	52.8	69.4
9/2/99	McSharry	48	63

* Results after exercise

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others. Since claimant has been denied the right to cross examine Pritchard on tests he performed on February 9, 1999, the tests are given no weight. *See United States Pipe & Foundry Co. v. Webb*, 595 F. 2d 264 (5th Cir. 1979). Also, Dr. Castle's medical report and conclusions rely in part on Prichard's test results. In so far as Dr. Castle's opinion relies on the results of tests that have been afforded no weight, the opinion can be afforded no weight. *See U.S. Mining Co. v. Director*, 187 F.3d 384 (4th Cir. 1999) (To assure both a fairness in the process and an outcome consistent with the underlying statutory scheme, the ALJ has, under §§556(d) of the Administrative Procedure Act, the affirmative duty to qualify evidence as "reliable, probative, and substantial" before relying upon it to grant or deny a claim. 5 U.S.C.§§ 556(d). Absent such a discipline to qualify evidence, administrative findings and orders could unacceptably rest on suspicions, surmise, and speculation.)

14. The following physicians reported on claimant's condition:

(a) Richard S. Buddington, M.D. examined claimant at the request of the Department of Labor on July 7, 1976. He diagnosed moderate chronic pulmonary disease and chest pain and noted a history of a recent hospitalization for cardiac disease. He considered a negative chest x-ray and concluded that claimant's primary pulmonary disease was probably distal airway obstruction. Dr. Buddington indicated that claimant had a moderate chronic respiratory impairment which prevented him from performing a variety of mining jobs.

(b) Vinod Modi, M.D. examined claimant relative to a hospital admission between May 25, 1980 and May 31, 1980. He diagnosed acute asthmatic bronchitis and chronic obstructive pulmonary disease- pulmonary emphysema.

(c) George O. Kress, M.D. examined claimant on October 7, 1980. He diagnosed chronic obstructive pulmonary disease with bronchitis and pulmonary emphysema. He found insufficient objective evidence for a diagnosis of pneumoconiosis. He concluded that claimant was disabled from his coal mine employment due to his severe obstructive respiratory impairment which he attributed to his years of cigarette smoking.

(d) Antonio T. Caday, M.D. examined claimant while he was hospitalized between October 10, 1980 and October 12, 1980. He diagnosed acute asthmatic bronchitis, minimal pneumoconiosis, and mild emphysema.

(e) Joseph J. Renn, III, M.D who is Board Certified in Internal Medicine and Pulmonary Diseases reviewed available medical records as indicated in reports dated March 19, 1984, September 19, 1999 and February 9, 2001. He diagnosed chronic obstructive pulmonary disease secondary to chronic bronchitis and emphysema with a bronchospastic component which is partially reversible. He found no pneumoconiosis but concluded that claimant's moderate ventilatory impairment would disable him from coal mine employment. He found no relationship between claimant's lung disease and his coal mine employment which he found consistent with an obstructive impairment due to cigarette smoking. These opinions remained unchanged in all three reports.

(f) Emory H. Robinette, M.D., who is Board Certified in Internal Medicine and Pulmonary Diseases, saw claimant on July 9, 1998 for a medical assessment of claimant's pulmonary disease at the request of one of claimant's treating physicians, Dr. Sutherland. In a letter dated August 12, 1998, Dr. Robinette indicated that claimant had evidence of some early interstitial fibrosis associated with emphysema and pleural parenchymal scarring with pulmonary function studies confirming a very severe obstructive ventilatory defect and marked air trapping. He further stated that claimant was a candidate for possible lung volume reduction surgery versus a transplant candidate, in view of his age of 61.

Dr. Robinette examined claimant again on April 12, 2000. He diagnosed the following conditions: 1) Coal workers' pneumoconiosis with a profusion abnormality of 1/1 with underlying emphysema; 2) Very severe chronic obstructive pulmonary disease with evidence of intercurrent

hypoxemia, hypercapnia and profound impairment of the diffusion capacity; and 3) History of hyperlipidemia. He also noted that there had been progressive deterioration of claimant's lung function since 1998. Dr. Robinette concluded that claimant was totally disabled from working on the basis of his lung disease alone and he stated that claimants' pulmonary disease is at least partially attributable to his prior coal mine employment.

(g) S.K. Paranthaman, M.D. who is Board Certified in Internal Medicine, Pulmonary Diseases and Critical Care Medicine examined claimant at the request of the Department of Labor on August 26, 1998. He diagnosed pulmonary disease and bronchospasm and concluded that claimant's respiratory impairment was severe and totally disabling. He stated that claimant's emphysema was likely related to his 15 year cigarete smoking history. He further indicated that if claimant's coal mine employment history were confirmed it could have significantly aggravated claimant's condition.

In a supplemental report dated November 6, 1998, Dr. Paranthaman reviewed records supplied by the Department of Labor and again indicated that claimant had severe pulmonary emphysema with marked airway obstruction causing a severe respiratory impairment. He felt that cigarette smoking was more likely the primary cause of claimant's respiratory condition but that his 15 years of coal mine employment and positive chest x-ray would point to the fact that claimant's respiratory condition could have been aggravated by coal dust exposure. He further concluded that claimant would qualify for a diagnosis of coal workers' pneumoconiosis since the legal definition of coal workers' pneumoconiosis includes any respiratory condition that is significantly aggravated by coal dust exposure.

(h) James R. Castle M.D., who is Board Certified in Internal Medicine and Pulmonary Diseases, examined claimant on February 9, 1999 and concluded that there was no evidence of coal workers' pneumoconiosis. He did diagnose the following conditions: 1) Chronic asthmatic bronchitis, tobacco smoke induced; 2) Severe partially reversible airway obstruction secondary to the above condition; 3) Coronary artery disease; 4) History of myocardial infarction; and 5) Angina pectoris, controlled. After reviewing other available medical records, Dr. Castle still concluded that claimant did not suffer from coal workers' pneumoconiosis. He concluded that claimant was totally disabled as a result of tobacco smoke induced asthmatic bronchitis manifested by severe airway obstruction which is partially reversible. He further stated that this disability is entirely unrelated to claimant's coal mine employment and coal dust exposure.

In supplemental reports dated September 24, 1999 and February 23, 2001 Dr. Castle indicated that he had reviewed additional medical records relative to this claim. He stated in these reports that his original opinions remained unchanged.

(i) A. Dahhan, M.D. who is Board Certified in Internal Medicine and Pulmonary Diseases, reviewed available records as indicated in his reports dated September 1, 1999, September 20, 1999, and February 9, 2001. He found insufficient objective data to justify a diagnosis of coal workers' pneumoconiosis. He did diagnose an obstructive pulmonary disability which would totally disable claimant from coal mine employment. He concluded that claimant's pulmonary disability did not result from coal dust exposure or occupational pneumoconiosis but rather was caused by his previous

smoking habit. He indicated that it was also contributed to by hyperactive airway disease or asthmatic bronchitis.

(j) Roger J. McSharry, M.D., who is Board Certified in Internal Medicine, Pulmonary Diseases and Critical Care Medicine, examined claimant on September 2, 1999. He found that claimant did not have pneumoconiosis. He did diagnose severe obstructive lung disease which he found to be suggestive of severe asthma and /or asthmatic bronchitis. Dr. McSharry testified to these opinions during a deposition which was taken on October 15, 1999. He testified that claimant's asthma was not related to his coal mine dust exposure. In a report dated February 20, 2001, Dr. McSharry indicated that he reviewed additional records but his opinions remained the same.

(k) Bruce N. Stewart, M.D. provided consultation reports dated September 16, 1999 and February 26, 2001 based on his review of the available medical records. Dr. Stewart, who is Board Certified in Internal Medicine and Pulmonary Diseases, found that claimant did not suffer from coal workers' pneumoconiosis. He did diagnose obstructive lung disease from asthma and cigarette smoking which would be totally disabling. He concluded that this impairment was not caused in whole or in part by coal workers' pneumoconiosis.

(l) Robert G. Loudon, M.D. also reviewed medical records as indicated in his reports dated September 26, 1999 and February 16, 2001. He found insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. He did diagnose a severe and disabling pulmonary or respiratory impairment, which he felt was the result of the miner's cigarette smoking habit and possibly associated with an asthmatic tendency. He concluded that this disability was not caused in whole or in part by pneumoconiosis.

(m) D.L. Rasmussen, M.D. examined claimant on January 3, 2001. He diagnosed pneumoconiosis and indicated that claimant suffers from a totally disabling respiratory insufficiency which is a consequence of both his cigarette smoking and his coal mine dust exposure. He concluded that claimant's coal mine dust exposure is a significant contributing factor to his disabling lung disease.

(n) The record includes an undated letter from one of claimant's treating physicians, Harold E. Schultz, D.O. in which he reviewed certain medical records relevant to this claim. He indicated that he had last evaluated the claimant on February 23, 2001, at which time he was "continuing to experience lung trouble and continued to be on a regimen of medication for the symptomology." He concluded, as claimant's treating physician and upon review of medical records, that claimant did suffer from coal workers' pneumoconiosis resulting from his exposure to coal mine dust during his coal mine employment.

Overview of the Black Lung Program

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally

disabled or contribute to his death.

Procedural History and Case Background

1. The miner filed his initial claim for benefits on July 26, 1974. However, claimant returned to coal mine employment at the end of 1974 and worked until November 1, 1975. A second claim for benefits was filed on March 3, 1976. *Dx.* 36.

2. A Decision and Order denying this claim for benefits was issued by Administrative Law Judge Frank Marcellino on October 19, 1984. *Dx.* 36-44.

3. Claimant appealed to the Benefits Review Board who issued a Decision and Order affirming the denial of benefits on December 16, 1986. *Dx.* 36-49.

4. The present claim for benefits was filed on July 8, 1998. *Dx.* 1.

5. On March 30, 1999, the district director issued a determination of eligibility for benefits. Dx.28.

6. Employer controverted and requested a hearing. Dx. 31.

7. By letter dated April 29, 1999, the Department of Labor indicated that the Black Lung Disability Trust Fund would begin paying benefits. Dx. 34.

8. The claim was referred to this Office for hearing and adjudication on May 24, 1999. Dx. 37.

9. On February 15, 2001, in compliance with the U.S. District Court's February 6, 2001 *Preliminary Injunction Order* in *National Mining Ass'n. v. Elaine L. Chao*, the undersigned issued a *Post-Hearing Order* directing the parties to state whether the amended regulations would affect the outcome of this claim. However, in *National Mining Ass'n et al v. Chao*, Civil Action no. 00-3086(D.D.C.2001), District Judge Emmet Sullivan dissolved his Preliminary Injunction Order which required a stay of all black lung cases wherein the amended regulations could affect the outcome. The court concluded that the amended regulations were valid and upheld their application. More recently, on June 14, 2002, the D.C. Circuit Court of Appeals issued its decision upholding the applicability of the amended regulations with the exception of a few provisions found to be impermissibly retroactive and a cost shifting provision found to be invalid. See *National Mining Ass'n., et al. v. Dep't of Labor*, __F.3d__, Case No. 01-5278 (D.C. Cir. June 14, 2002)

Issues Presented for Adjudication

The contested issues as stated on the CM-1025 and which were confirmed at the hearing in this case are: (1) whether the miner suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) whether the miner is totally disabled; and (4) whether his total disability is caused by pneumoconiosis. *Dx.* 37 Tr. 8.

In regard to the issue of length of coal mine employment Employer indicated that it did not contest Judge Marcellino's earlier finding of fifteen years which I also find to be reasonable and supported by the record and testimony.

The Standard for Entitlement

Because this claim was filed in July of 1998, it is governed by the regulations at 20 C.F.R. Part 718.[3] Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) that he suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) that he is totally disabled; and (4) his total disability is caused by pneumoconiosis. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Evidence which is in equipoise is insufficient to sustain Claimant's burden in this regard. *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), *aff'd sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

As stated earlier in the procedural history, the present claim, which was filed on July 8, 1998, was filed more than one year after the claimant's previous claim was denied. Therefore, pursuant to §725.309, this claim must be denied as a duplicate claim unless the claimant can show that there has been a material change in conditions since the prior denial. If the claimant is successful in showing such a change, then his claim must be evaluated under Part 718, as amended. *Dotson v. Director, OWCP*, 14 B.L.R. 1-10 (1990)(en banc). The administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated a material change in conditions and all of the record evidence must then be evaluated to determine if he is entitled to benefits under the Act. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996)(*en banc).*

Claimant's previous claim was decided under the Part 727 regulations. The administrative law judge determined that claimant had invoked the interim presumption on the basis of x-ray, pulmonary function study, and medical opinion evidence but the presumption was rebutted on the basis that claimant's pulmonary impairment was caused by cigarette smoking and not by his coal dust exposure. Since the present claim is decided under the Part 718 regulations, all elements of entitlement must be proven independently, and all elements of entitlement are contested. Therefore, each element of entitlement will be reviewed to determine if claimant has proven a material change in conditions on the basis of newly submitted evidence. Ultimately, if claimant can prove all elements of entitlement based on the evaluation of all evidence of record, claimant will be entitled to benefits.

Existence of Pneumoconiosis and its Etiology

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[3] As the miner last engaged in coal mine employment in the Commonwealth of Virginia, appellate jurisdiction of this matter lies with the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201. Moreover, the regulations at 20 C.F.R. § 718.203(b) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a).[4]

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[4] The presumptions contained at §§ 718.304 - 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

Section 718.202(a)(1) provides that the presence of pneumoconiosis may be established by x-ray. Pursuant to the criteria of Section 718.102, to establish the existence of pneumoconiosis, an x-ray must be read to show Category 1, 2, 3, A, B, or C, according to the ILO-U/C International Classification of Radiographs. The regulation at 20 C.F.R. § 718.202(a)(1) also requires that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[5] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, greater weight may be accorded the x-ray interpretation of a dually-qualified physician (B-reader and board-certified radiologist) over a physician who is only a B-reader. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

The chest roentgenogram evidence has previously been summarized. Of the 68 x-ray interpretations covering a 27 year span of time from 1974 to 2001, a preponderance of the readings are negative for the presence of pneumoconiosis. In particular, there are only 11 positive interpretations. Dr. Scott, a dually-qualified physician, concluded that a study dated August 5, 1974 was positive. However, he later interpreted studies dated August 1978, January 1999, February 1999, August 1999, September 1999, and January 2001 as negative for the presence of the disease. Dr. Scott does not explain the change in his interpretations such that his readings are entitled to less weight. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984).

Five physicians, one of whom is dually-qualified, interpreted the May 1982 study as positive for the existence of pneumoconiosis. There are no contrary readings of this study and it supports a finding of the disease.

Similarly, Dr. Gaziano, a B-reader, concluded that the August 1998 study was positive for the presence of pneumoconiosis. His reading is outweighed by the seven negative interpretations of the study by one B-reader and six dually-qualified physicians. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 101 (1999) (it is proper to accord greater weight to a dually-qualified physician over a physician who is a B-reader).

Dr. DePonte, a dually-qualified physician, concluded that the January 1999 study was positive for the existence of pneumoconiosis. However, her reading is outweighed by the negative findings of eight other dually-qualified physicians. Particular weight is accorded Dr. Wiot's negative interpretation since he assisted in the development of the ILO-U/CC classification system. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985).

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[5] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

Dr. Robinette, a B-reader, concluded that the August 1999 study was positive for the presence of pneumoconiosis but his interpretation is outweighed by the three negative interpretations of the study by dually-qualified physicians. *See Cranor, supra*.

Dr. Robinette also found that the March 2000 study was positive for the existence of pneumoconiosis. There is no contrary interpretation of this study. However, a study conducted in September 1999 was interpreted as negative by four dually-qualified physicians and a physician with unknown qualifications.

A subsequent study, dated January 3, 2001, was interpreted as positive for the existence of pneumoconiosis by one dually-qualified physician whereas five dually-qualified physicians concluded that the study was negative. It is determined that the preponderance of the readings for this study do not support a finding of pneumoconiosis.

Given the temporal proximity between the March 2000 study interpreted as positive by Dr. Robinette, a B-reader, and the September 1999 and January 2001 studies interpreted as negative by dually-qualified physicians, it is determined that a preponderance of the recent studies of record do not support a finding of pneumoconiosis. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988) (the length of time between x-ray studies and the qualifications of the interpreting physicians are factors to be considered).

Upon review of all of the studies of record, the dually-qualified physicians, who have superior credentials on this record, have preponderantly concluded that the chest x-ray evidence does not demonstrate the presence of pneumoconiosis. As a result, claimant has not carried his burden under 20 C.F.R. § 718.202(a)(1) (2001).

Subsection 718.202(a)(2) provides that a biopsy or autopsy may form the basis for a finding of the existence of pneumoconiosis. No such evidence has been submitted in this case. Therefore this provision is not applicable.

The final method by which claimant can establish that he suffers from the disease is by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19(1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65(1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295(1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R.1-49(1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially

aggravated by coal dust exposure. *Wilburn v. Director, OWCP,* 11 B.L.R. 1-135 (1988).

The medical opinion evidence submitted since the denial of claimant's previous claim was briefly summarized above. It consists of the reports of five physicians who performed pulmonary evaluations, in addition to a brief report by claimant's treating physician, Dr. Schultz, and the consultation reports of four physicians based on their review of medical records.

Dr. S.K. Paranthaman examined claimant on August 26, 1998. He considered claimant's occupational and medical histories, as well as a smoking history of 15 pack years. He considered an x-ray, which was interpreted as negative, a pulmonary function study, a blood gas test, and an EKG. He diagnosed pulmonary emphysema and bronchospasm noting that the claimant had a severe respiratory impairment which would totally disable claimant from his former coal mine employment. He stated that claimant's impairment was likely related to his cigarette smoking history but further stated that his coal mine employment could have aggravated his condition if properly documented. After reviewing further documentation of claimant's coal mine employment and additional records supplied by the Department of Labor, Dr. Paranthaman stated in a supplemental report dated November 6, 1998 that claimant's respiratory condition could have been aggravated by coal dust exposure. He also stated that claimant would qualify for a diagnosis of coal workers' pneumoconiosis since the legal definition of coal workers' pneumoconiosis includes any respiratory condition that is significantly aggravated by coal dust exposure.

Dr. Roger J. McSharry performed a pulmonary evaluation of the claimant on September 2, 1999. He reviewed claimant's occupational, medical and smoking histories, as well as his reported symptoms of shortness of breath, daily productive cough, wheezing and chest pain. Clinical testing included a chest x-ray, pulmonary function and blood gas tests and an EKG. He diagnosed severe obstructive lung disease which he found to be suggestive of severe asthma and/or asthmatic bronchitis. He testified during deposition testimony that claimant's asthma was not related to his coal mine dust exposure.

Dr. Emory H. Robinette examined claimant on two occasions. The first time was on July 9, 1998 for a consulting medical assessment of claimant's pulmonary disease at the request of one of claimant's treating physicians, Dr. Sutherland. He found evidence of some early interstitial fibrosis associated with emphysema and pleural parenchymal scarring with pulmonary function studies confirming a very severe obstructive ventilatory defect and marked air trapping. He concluded that claimant was a candidate for possible lung volume reduction surgery versus a transplant candidate, in view of his age at 61.

Dr. Robinette performed another pulmonary evaluation of the claimant on April 12, 2000. He reviewed claimant's history and symptoms as well as records supplied from Dr. Sutherland's office documenting a long standing history of progressive pulmonary disease. He considered a chest x-ray, pulmonary function study, blood gas test and EKG. He diagnosed coal workers' pneumoconiosis with a profusion abnormality of 1/1 with underlying emphysema and very severe chronic obstructive pulmonary disease with evidence of intercurrent hypoxemia, hypercapnia and profound impairment of the diffusion capacity. He noted that there had been progressive deterioration of claimant's lung function since 1998 and that claimant's pulmonary disease was at

least partially attributable to his prior coal mining employment.

Dr. D.L. Rasmussen examined claimant on January 3, 2001. He considered claimant's history and symptoms which included progressive shortness of breath on exertion for twenty years, chronic productive cough, wheezing and chest pain. Clinical testing consisted of a chest x-ray, pulmonary function study and EKG. Dr. Rasmussen indicated that it was medically reasonable to conclude that claimant had coal workers' pneumoconiosis in light of his occupational history and positive x-ray findings. He also concluded that claimant had severe and totally disabling respiratory insufficiency with the two causal risk factors being his cigarette smoking history and his coal mine dust exposure. He stated that neither could be dismissed as a potent cause and that his "loss of lung capacity is no doubt the consequence of the combined effects of his cigarette smoking and his coal mine dust exposure." Dr. Rasmussen's report also cites and discusses several articles supporting the relationship between coal mine dust exposure and chronic obstructive lung disease.

The record also includes the undated letter from one of claimant's treating physicians, Harold E. Schultz, in which he reviewed certain relevant medical records dating between 1974 and 2001. He indicated that he last evaluated the claimant on February 23, 2001, at which time he was "continuing to experience lung trouble and continued to be on a regimen of medication for the symptomology." He concluded, as claimant's treating physician and upon review of medical records, that claimant did suffer from coal workers' pneumoconiosis resulting from his exposure to coal mine dust during his coal mine employment.

The record also includes the consultation reports of Drs. Dahhan, Stewart, Loudon,and Renn based on their review of available medical records. These reports have been previously summarized. Each of these pulmonary experts concluded that claimant suffered from a totally disabling obstructive impairment, but concluded that he did not suffer from coal workers' pneumoconiosis. Each of these physicians attributed claimant's obstructive impairment to his history of cigarette smoking and asthma unrelated to coal dust exposure.

After reviewing all of the medical opinion evidence submitted since the denial of claimant's previous claim, it is determined that claimant has not demonstrated the existence of pneumoconiosis on the basis of medical opinion evidence. As previously set out, the definition of "'(l)egal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. § 718.201 (2001).

Drs. Paranthaman, Robinette, Rasmussen and Schultz, all of whom had the opportunity to examine claimant and review test results, concluded that claimant did have pneumoconiosis or that his totally disabling lung impairment was related in significant part to his coal mine dust exposure. Dr. Robinette is Board Certified in Internal Medicine and Pulmonary Diseases.

Dr. Schultz was one of claimant's treating physicians and Dr. Robinette consulted with another one of claimant's treating physicians, Dr. Sutherland, in regard to the treatment of claimant's severe lung disease. It would be proper to accord greater weight to the well-reasoned, well-documented treating physicians' opinions given that they have examined claimant over a period of

time. 20 C.F.R. § 718.104(d) (2001); *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992). However, in this case, the examining and treating physicians' opinions are not well-reasoned and they do not persuade the undersigned that claimant suffers from coal workers' pneumoconiosis or that he is totally disabled from the disease. In *Peabody Coal Co. v. Groves*, ___ F.3d ___, Case No. 00-3867 (6th Cir. Jan. 17, 2002), the Sixth Circuit held that treating physicians' opinions may be entitled to greater weight than the opinions of other physicians of record, but that ALJs "'are not required to credit treating doctors' opinions either standing alone or where there is conflicting proof in the record.'" The court cited to the amended regulatory provisions at 20 C.F.R. §§ 718.104(d)(5) (2000) which provide that weight accorded to the treating physician's opinion must "also be based on the credibility of the physician's opinion in light of its reasoning and documentation" and "other relevant evidence as a whole."

Drs. Robinette and Rasmussen noted a progressive deterioration of claimant's lung function since 1998 or 1999. Dr. Rasmussen referenced several articles which support a finding that coal dust exposure may cause a purely obstructive impairment. The undersigned agrees. 20 C.F.R. § 718.201 (2001). However, while Dr. Rasmussen opines that coal dust exposure caused, in part, claimant's severe obstructive ventilatory defect, he failed to explain this finding in light of the fact that all of the physicians who addressed claimant's pulmonary function study results noted that his obstructive defect was "significantly" or "markedly" reversible. Marked reversibility on ventilatory testing does not support a finding of coal workers' pneumoconiosis, which is a progressive and "irreversible" disease process. *Lane Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1992). Drs. Robinette and Shultz likewise do not explain the inconsistency between their diagnoses of coal workers' pneumoconiosis and claimant's reversible obstructive defect. *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). Drs. Dahhan, Stewart, McSharry, Loudon, and Renn found that the significant reversibility of the miner's obstructive disease precluded a diagnosis of coal workers' pneumoconiosis; rather, they diagnosed the miner with smoking induced chronic obstructive pulmonary disease and asthma or asthmatic bronchitis.[6]

In addition, a majority of the physicians of record noted that claimant had normal diffusing capacity. Drs. Renn and Dahhan stated that claimant's normal diffusing capacity militated against a finding of coal workers' pneumoconiosis. Dr. McSharry noted that a normal diffusing capacity, as in this case, lends further support to a finding that the miner suffers from asthma. Drs. Rasmussen and Shultz fail to explain the importance of this finding in their diagnoses and they fail to explain how a normal diffusing capacity would not detract from a finding of coal workers' pneumoconiosis.[7]

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[6] There is a significant discrepancy in the miner's reported smoking history–from 15 to 33 pack years. At the hearing, the miner stated that he smoked from age 19 or 20, which would have been 1956, and he quit smoking in 1986. *Tr.* at 43. He further noted that he quit smoking in the interim on two or three occasions for two or three years at a time. *Tr.* at 43. As a result, claimant is credited with a 21 pack year smoking history.

[7] Dr. Robinette is the only physician of record to state that the miner had a severely impaired diffusing capacity. All of the remaining physicians found that the miner's diffusing capacity was normal.

As a result, a preponderance of the newly submitted medical evidence does not support a finding of coal workers' pneumoconiosis and this is consistent with the preponderantly negative x-ray interpretations of record. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000); *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986). Accordingly, it is determined that claimant has not demonstrated a material change in conditions since the denial of his previous claim.

Although claimant has failed to establish that he suffers from coal workers' pneumoconiosis, he has established total disability. Section 718.204(c) sets forth certain criteria, including pulmonary function tests, blood gas tests, and the reasoned medical opinions of physicians to be used in determining whether a miner is totally disabled.

Subsection 718.204(c)(1) provides that a pulmonary function study may establish total disability if its values are equal to or less than those listed in Appendix B of the Part 718 regulations. Claimant's pulmonary function studies have been set out earlier herein.

For a miner of the claimant's height, which is 71.3 inches (based on an average of reported heights), §718.204(c)(1) requires an FEV1 equal to or less than 2.14 for a 61 year-old-male, decreasing to 2.10 for a 63 year-old-male. If such an FEV1 is shown, there must be, in addition, an FVC value equal to or below 2.72; or an MVV value equal to or below 85 for a 61 year-old-male decreasing to 2.69 and 84 for a 63 year old male, or a ratio equal to or less than 55 percent, when the results of the FEV1 test are divided by the results of the FVC test.

All four of the pulmonary function studies submitted since the denial of claimant's previous claim indicate qualifying values. Thus, the pulmonary function study evidence does support a determination that claimant suffers from a totally disabling respiratory or pulmonary impairment pursuant to §718.204(c)(1).

Claimant may also demonstrate total disability due to pneumoconiosis based on the results of blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the bloodstream. 20 C.F.R. §718.204(c).

The record includes three blood gas studies which have been submitted since the denial of claimant's previous claim. Only the February 9, 1999 study indicates qualifying values. Thus, it is determined that the blood gas test evidence does not establish the claimant's total disability.

Under §718.204(c)(3), total disability may be shown by medical evidence that claimant suffers from cor pulmonale with right-sided congestive heart failure. The evidence does not establish that claimant is suffering from cor pulmonale.

Claimant may also show total disability under Section 718.204(c)(4) by the reasoned medical judgment of a physician based on medically acceptable clinical, laboratory and diagnostic techniques. Under this section all relevant probative evidence must be considered, with the burden of proof on the claimant, to establish total disability by a preponderance of the evidence. *See Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

All of the medical opinions submitted since the denial of claimant's earlier claim have been summarized above. Each of these opinions concluded that claimant suffers from a severe, totally disabling respiratory or pulmonary impairment. The opinions are further supported by the ventilatory testing of record. The only disagreement among the physicians is whether claimant's totally disabling respiratory impairment is due to pneumoconiosis. The amended regulations at § 718.204(c)(1) state that claimant's total disability will be considered due to pneumoconiosis if pneumoconiosis is a "substantially contributing cause" of the miner's totally disabling respiratory impairment. Pneumoconiosis is a substantially contributing cause if it has a "material" adverse effect on the miner's respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment. Because the undersigned has concluded that the miner does not suffer from coal workers' pneumoconiosis, it is determined that the opinions of Drs. Loudon, Renn, Castle, Dahhan, McSharry, and Stewart, who conclude that the miner's total disability stems from his smoking induced chronic obstructive pulmonary disease and asthma unrelated to coal dust exposure, are accorded the greatest weight. Consequently, claimant has not sustained his burden of establishing total disability due to coal workers' pneumoconiosis. Accordingly,

ORDER

IT IS ORDERED that the claim for benefits filed by Donald Church is hereby denied.

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.